STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. B-09/08-420
	)	
Appeal of	)	

INTRODUCTION

The petitioner appeals the decision by the Department for Children and Families, Health Access Eligibility Unit (HAEU) finding her son ineligible for Disabled Children's Home Care (DCHC or "Katie Beckett") benefits under Medicaid.

On September 15, 2008, HAEU sent petitioner a Notice of Decision that her son had been found disabled by the Disability Determination Services but that he was ineligible for DCHC services because he was not in need of institutional level of care. Petitioner was informed to contact the Social Security Administration to see if her son was eligible for Social Security benefits.[1] Petitioner filed for fair hearing on or about September 18, 2008.

The issue is whether the child meets the eligibility requirements of the DCHC program.

A status conference was held on October 2, 2008 at which the petitioner supplied the Department with additional

[1] In HEAU's internal documents, they state petitioner's son does not meet eligibility criteria for a disability. This is at odds with the official notification sent to petitioner and will be discussed below.

information and at which the Department agreed to send petitioner a copy of her son's file and legal references. A status conference was held on November 3, 2008 at which the Department stated that the additional materials did not change their analysis.

A fair hearing was held on November 14, 2008; petitioner testified at that time. The parties stipulated to entry of exhibits. Petitioner submitted a pre-hearing legal memorandum. The record remained open until November 24, 2008 to allow the Department to submit legal argument. The decision is based upon the evidence adduced at hearing and the parties' memoranda.

FINDINGS OF FACT

1. The petitioner lives with her son and daughter. The DCHC application was made on behalf of petitioner's son, I.B-F. (child), who is currently nine years old. The petitioner and her husband recently initiated a divorce action; petitioner provides primary day to day care of the minor children of the marriage. The petitioner home-schools her children and has done so for approximately the past three years.

The child has experienced developmental delays since birth and has experienced psychological difficulties for many years.

Medical Evidence

2. Dr. S.H. has been the child's pediatrician since his birth. He submitted a letter dated September 28, 2008. He noted that the child did not have words until he was 18 months old. He noted a history of medications typically used for attention deficit disorder that did not help the child. He stated that a recent evaluation led to a diagnosis for autism and anxiety disorder. He wrote:

> [child's] mother states that [child] tends to do well out in public but when he gets home he decompensates behaviorally. I have had other patients with autism and anxiety who have exhibited a similar profile.

3. Dr. D.D. is a psychiatrist who has treated the child since April 2005; treatment includes regular counseling and medications. Dr. D.D. submitted a letter dated August 5, 2008 noting that the child's "development has shown multiple signs of emotional and social delay". Based on a working diagnosis of PDD, NOS (pervasive developmental delay), he prescribed Prozac, clonopin, amitriptyline, lamictal and risperdal. Dr. D.D. explained that the child had been evaluated by the Stern Center, the Philo Center, a clinical

psychologist, and a discharge diagnosis was pending from an emergency placement.

Dr. D.D. submitted an updated letter on October 1, 2008 supporting a diagnosis of Aspergers/Autistic Spectrum Disorder based on recent reports.

4. Dr. D.D. referred the child to the Stern Center for Language and Learning in December 2007 for information to refine the diagnosis and treatment. The reason for referral noted increased outbursts and obsessions with violence and death. The Neuropsychological evaluation was conducted by S.G., a clinical neuropsychlogist and licensed psychologist-doctorate, and N.E., MS, CCC-SLP, communications specialist. The child has a full scale IQ of 102. Their evaluation was based on observations, information from parents, and a wide range of tests and procedures. Their DSM-IV diagnoses were 299.80 Pervasive Developmental Delay, NOS, rule out thought disorder, rule out obsessive compulsive disorder. In their interpretation, they wrote:

> [child] is an 8 year old boy with a set of increasingly alarming behaviors and thought processes that suggest the need for more intensive intervention to help achieve stabilization of his mood and behavior. [child's] family is very concerned about his current ability to be safe at home. He has an early developmental history from the parent's report of delays in language and social relating seen in the home, but not reported outside the home. There have also been long standing

> symptoms of anger outbursts and inappropriately violent behaviors, which suggest the present of mood instability....[child] requires psychiatric medication, emotional/behavioral interventions, and social skills group to address his symptoms. **Support for these additional rule out diagnoses at present is warranted in addition to a follow up team evaluation at a more extensive psychiatric facility, to provide his family and [child] with services to maintain his safety and further clarify possible etiologies.**

In addition, they listed a range of options if the child did not respond to current treatments; this list included talk therapy to partial hospitalization to inpatient care only if the child's behavior threatened himself or his family.

5. Dr. D.D. referred the child to the Philo Center for an occupational therapy evaluation in December 2007. The evaluation was performed by C.P., an Occupational Therapist Registered/Licensed, who observed the child and administered a number of tests to assess the child's sensory integration/processing/modulation and defensiveness as well as fine motor skills. The report summary includes the following:

> Standardized and normative testing reveals that [child] performs within developmental expectations in the areas of fine motor precision, fine motor integration, bilateral coordination, visual perception and visual-motor coordination. Testing also reveals delays in visual-motor integration, manual dexterity, upper-limb coordination and balance. Clinical observations exhibit inefficient sensory processing skills. Challenges in

> these foundational skills are most certainly impacting his performance with his gross motor and fine motor skill development. In addition [child] shows positive symptoms of sensory modulation difficulties which contribute to his activity level.

The Philo Center recommended professional occupational therapy and a list of activities the family could do in the home.

6. The child was referred to the Howard Center for developmental disability services. The Howard Center, in turn, referred the child to D.S., Psychologist-Masters, for an eligibility assessment. D.S. reviewed the Stern Center report and used the Autism Diagnostic Observation Schedule, the Autism Diagnostic Interview-Revised, and the Adaptive Behavior Assessment System-II. In his report of June 11, 2008, D.S. concluded:

> [child] has observational ratings from the ADOS and ADI-R that indicate and support a diagnosis of Pervasive Developmental Disorder, Autistic Disorder, with the following criteria met from DSM-IV/TR:
>
> (1) Qualitative impairment in social interaction:
>
> - Failure to develop peer relationships appropriate to developmental level
> - A lack of spontaneous seeking to share enjoyment, interests, or achievements with other people
> - Lack of social and emotional reciprocity
>
> (2) Qualitative impairments in communication:
>
> - Delay in spoken language and failure to compensate through gestures

- Marked impairment in the ability to initiate and sustain a conversation with others

(3) Restricted, repetitive and stereotyped patterns of behavior, interests and activities:

- Encompassing preoccupation with several restricted patterns of interest that have varied through development.

There has been delays and abnormal functioning with the onset prior to age 3 for social interaction, and language as used in social communication.

D.S. found the child eligible for developmental services based on PDD: Autistic Disorder with "substantial deficits in adaptive behavior"

On August 20, 2008, D.S. prepared an addendum to his report after the child's father completed the ADI-R. The father's observations were consistent with petitioner's prior observations in that the child was above the cut-off for qualitative abnormalities in reciprocal social interaction, abnormalities in communication, and for restrictive, repetitive and stereotyped patterns of behavior. D.S. iterated his eligibility decision.

7. On July 14, 2008, the child was admitted to an emergency placement through the Howard Center at Jarrett House. He remained at Jarrett House until July 22, 2008. He was admitted by First Call, an emergency service, due to

increasingly aggressive behavior at home and due to suicidal ideation. The discharge summary notes extreme stressor's from the parents' divorce. During his placement, the child did well with the structure of his program and being away from his parents' divorce. The discharge summary includes a diagnosis of adjustment disorder with mixed disturbance of emotions and conduct, r/o autism spectrum disorder, r/o anxiety disorder.

Additional Evidence

8. The petitioner testified at the hearing and explained her concerns for her child. She gave a history of the child's developmental delays that are consistent with the above diagnosis for Asperger's Syndrome. The child continues with counseling and medication from Dr. D.D. and with sensory integration services through the Philo Center. She is seeking a one on one aide to work on occasion with the child and seeking additional programming/supports.

9. The child attended public school through second grade. Petitioner explained that the family liked to travel and the child had a large number of school absences. A plan for the school district to evaluate the child did not occur

since the family elected to home school the child.[2] The petitioner has been approved to home school the child and his sister for the past three years. This school year, petitioner worked with the school district so that the child has limited but highly structured participation at the school for physical education.

10. Petitioner describes the child as fixated on a narrow range of interests including fishing, weapons, and the weather. Transitioning the child to other subjects is difficult. The child has difficulties with transitions in general and can act out when he needs to transition to a new activity. According to petitioner, the child is very sensitive and reactive to both external and internal stimuli. She has safety concerns at times. She has pulled off to side of the road when child is set off and starts acting out in the car.

11. The petitioner characterized the child's play as violent. His actions can be disturbing to others. Petitioner submitted a letter from the child's sister and an e-mail from an adult half-sister that iterate her description of his play.

[2] If the child were enrolled in the school system, the petitioner could initiate an evaluation with the school district for either Section 504 services or special education.

12. The petitioner uses First Call, an emergency call-in service operated by the Howard Center. Her calls reflect times when the child has expressed suicidal ideation, been emotionally disruptive or been noncompliant.

ORDER

The Department's decision is affirmed because the child does not meet the level of institutional care contemplated under the DCHC program.

REASONS

The DCHC or "Katie Beckett" program provides more liberal financial eligibility criteria for Medicaid to certain children with extraordinary medical needs.[3] The goal is to encourage and support families to provide home-based care for children who might otherwise be in an institution.

To qualify, it must be shown that the child meets the criteria of M200.23(e) which are:

- require the level of care in a medical institution;
- would be eligible for Medicaid if they were living in a medical institution;

[3] Medicaid eligibility in this context includes a finding that the child is disabled. The Department uses the criteria developed by the Social Security Administration for determining whether a child's medical condition rises to the level of disability. Appendix 1 of 20 C.F.R. § 404. Although the Department argues that the child is not disabled, the Department's September 15, 2008 notice stated otherwise and was the basis of this appeal. Further, for purposes of this decision, the child's condition does not rise to the level of needing institutional care.

- can receive appropriate medical care in the community, the cost of which is no greater than the estimated cost of medical care in an appropriate institution;
- are age 18 or younger;
- have income, excluding their parents' income, no greater than the institutional income standard; and
- have resources, excluding their parents' resources, no greater than the resource limit for a Medicaid group of one.

The parties agree that the child meets the criteria in M200.23(e) with the exception of whether he is requires the level of care in a medical institution. In particular, does the petitioner's child need the level of medical or personal care provided by a nursing home, intermediate care facility for the mentally retarded (ICF-MR) or hospital. P2421.C(2). The petitioner has the burden of proof in this case.

The Department has developed criteria for admission to an ICF-MR in a Department memorandum dated February 24, 1993. The criteria are:

> a. The individual is mentally retarded or has a related condition, AND
>
> b. The individual has one of the following:
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> (1) A severe physical disability requiring substantial and/or routine assistance in performing self-care and daily living functions;
>
> (2) Substantial deficits in self-care and daily living skills requiring intensive, facility-based training; or

> (3) Significant maladaptive social and/or interpersonal behavior patterns requiring an ongoing, professionally-supervised program of intervention.

Petitioner's child has a related diagnosis to mental retardation. Being on the autism spectrum is considered a related diagnosis under the Vermont Developmental Disabilities Act of 1996, 18 V.S.A. § 8722(2)(A). But, the evidence does not support the second prong for eligibility.

Petitioner has faced many hurdles seeking a proper diagnosis for the child and accessing appropriate services. She has been the main caregiver; her frustration at finding services is understandable. Developmental disability services through the local mental health agencies are underfunded and not available to petitioner.

But, the DCHC waiver is limited to the institutional level of care found in nursing homes or ICF-MRs; it does not encompass short-term or emergency therapeutic placements. The program is meant for extraordinary cases. Substantial deficits in self-care or living skills sufficient for institutional care are typically substantial deficits in activities of daily living such as feeding oneself, dressing oneself, etc. Although the child has certain delays, he does not fall within this category. In addition, the evidence

does not rise to the level of maladaptive behaviors contemplated in this program.

Accordingly, the Department's decision is affirmed. 3 V.S.A. § 3091(d), Fair Hearing Rule No. 1000.4(D).

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